SURGERY

TECHNICAL MANUAL

Version 3.0
July 1993

(Revised April 2003)

Department of Veterans Affairs
V*IST***A** System Design & Development

Revision History

The table below lists changes made since the initial release of this manual. Use the Change Pages document to update an existing manual or use the entire updated manual.

Note: The Change Pages document may include unedited pages needed for two-sided copying. Only edited pages display the patch number and revision date in the page footer.

Date	Revised Pages	Patch Number	Description
04/03	Title Page, i, v – vi, 67-69	SR*3*115	- Updated Title page, Revision History, and Table of Contents. - Added new fields TIME OUT VERIFIED and IMAGING CONFIRMED to the SURGERY file (#30) listing; this addition caused the pages to wrap.
02/03	Title Page, I, 15, 69-70, 71, 124, 185	SR*3*107	- Updated Title page and Revision History. - Added new field AUTOMATED CASE CART ORDERING to the SURGERY SITE PARAMETERS file (#133) listing. - Added new fields SPD COMMENTS and DYNAMED NOTIFIED to the SURGERY file (#130) listing; this addition caused the pages to wrap. - Added callable routine CSLSUR1 to the Calls Made by Surgery section.
12/02	185 - 186	SR*3*111	- Added callable routine DGUTL4 to the Calls Made by Surgery section.
11/02	Title Page, i, (ii) 13, (14) (55), 56 (119), 120 (185), 186	SR*3*109	Updated Revision Date and Revision History. - Changed the field name DEFAULT BLOOD REQUEST to DEFAULT BLOOD COMPONENT. - Changed the definition of the field REQ BLOOD KIND from a pointer to the BLOOD PRODUCT file (#66) to a free text field. - Deleted DEFAULT BLOOD REQUEST field, and replaced with DEFAULT BLOOD COMPONENT field. - Added callable routine VBECA5A to the Calls Made by Surgery section.
07/93			Original Release of Technical Manual.

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63 IV STARTED BY POINTER
This is the name of the person that started the IV for this operative procedure.

64 CULTURES WORD-PROCESSING
These are the names of cultures sent to the laboratory for examination.

65 SURGERY POSITION POINTER
This is the position in which the patient is placed for this operative procedure. This information will appear on the Nurse Intraoperative Report.

.01 SURGERY POSITION POINTER
This is the position in which the patient is placed for this operative procedure. More than one position may be entered for each case.

1 TIME PLACED DATE/TIME
This is the date/time that the patient was placed in this position. Times without a date can be entered.

66 PRIN DIAGNOSIS CODE POINTER
This is the principal ICD9 diagnosis code. It should be entered for all cases and will be used for Surgery Central Office reporting needs.

67 CANCELLATION AVOIDABLE SET
This field contains a set of codes used to flag a cancellation as being avoidable or unavoidable. It is used when determining the percentage of avoidable cancellations.

68 SCHEDULED PROCEDURE FREE TEXT
This field contains the scheduled (or original) principal procedure for this case. It will be compared to the actual procedure completed.

69 CODING VERIFIER POINTER
This is the person who last updated procedure and/or diagnosis descriptions and/or codes for this case using the Update/Verify Procedure/Diagnosis Codes [SRCODING EDIT] option. This field is updated automatically by the option when information is changed.

70 CANCELLED BY POINTER
This is the name of the person who cancelled this surgical case. This information is automatically entered when a case is cancelled.

71 TIME OUT VERIFIED SET
This field refers to the completion of a "Time Out" verification process prior to the start of the procedure. Enter YES if the "Time Out" verification process was completed prior to the start of the procedure. If entered "NO", a justification should be documented in the Nursing Care Comments.

72 IMAGING CONFIRMED SET
This field refers to the completion of the verification process for the presence of relevant imaging data to confirm that the operative site for the correct

patient are available, properly labeled and properly presented, and verified by two members of the operating team prior to the start of the procedure.

80 SPD COMMENTS WORD-PROCESSING
This field contains any information for SPD that cannot be entered elsewhere. These comments will be sent to SPD via the Surgery/CoreFLS interface.

81 DYNAMED NOTIFIED SET
This field indicates whether or not a notification has been sent to DynaMed by way of the CoreFLS interface. YES indicates at least one notification has been sent, while a null value or zero indicates that no notification has been sent. The first notification sent to DynaMed will be a NEW APPOINTMENT notification. Subsequent notifications will be for editing, canceling, or deleting notifications, as appropriate.

100 ORDER NUMBER POINTER
This is the pointer to the ORDER file (100). It will be created when a case is requested.

101 STAFF/RESIDENT SET
This determines whether the surgeon was a resident or staff. It will be used for categorizing procedures in the Annual Report of Surgical Procedures.

102 REASON FOR NO ASSESSMENT SET
This is the reason why no assessment was entered for this particular surgical case. It should be entered if any major procedure was excluded from the risk assessment module.

1 - Patient did NOT receive general, spinal, or epidural anesthesia.
2 - Number of surgical cases entered into the Surgical Risk Study exceeded 36 over an 8-day time frame.
3 - Number of TURPs or TURBTs exceeded 5 cases over an 8-day time frame.
4 - Study exclusion criteria prohibits patient entry.
6 - Surgical Clinical Nurse Reviewer was on Annual Leave.
8 - Case was a concurrent case, secondary to an assessed primary case.
9 - Number of inguinal hernias exceeded 5 cases over an 8-day time frame.

103 ANESTHETIST CATEGORY SET
This field holds the category of the principal anesthetist, which is used on the Anesthesia AMIS report to enumerate the number of anesthetics administered by each category.

118 NON-OR PROCEDURE SET
This field is a flag signifying this case is a non-OR surgical procedure.

119 NON-OR LOCATION POINTER
This is the location (file 44) where this non-OR procedure was performed.

120 DATE OF PROCEDURE DATE/TIME

This is the date that the non-OR procedure was performed. The date of procedure must be entered for all non-OR cases.

121 TIME PROCEDURE BEGAN DATE/TIME
This is the date and time that the non-OR procedure began.

122 TIME PROCEDURE ENDED DATE/TIME
This is the date and time that all the procedures for this non-OR case are complete.

123 PROVIDER POINTER
This is the person who performs the major portion of the principal non-OR procedure. This field is required for several reports.

124 ATTEND PROVIDER POINTER
This is the name of the attending staff provider responsible for this case. This information appears on several reports.

125 MEDICAL SPECIALTY POINTER
This is the medical specialty credited for doing this non-OR procedure. Many reports are sorted by the medical specialty. This field should be entered prior to completion of this non-OR procedure.

126 PROCEDURE OCCURRENCE FREE TEXT
This is an occurrence that is related to a non-O.R. procedure. If there are not any non-O.R. procedure occurrences, this field should be left blank. Do not enter 'NO' or 'NONE'.

.01 PROCEDURE OCCURRENCE FREE TEXT
This is an occurrence that is related to a non-O.R. procedure. If there are not any non-O.R. procedure occurrences, this field should be left blank. Do not enter 'NO' or 'NONE'.

1 OUTCOME TO DATE SET
This is the outcome to date of this non-O.R. procedure occurrence.

2 DATE OCCURRENCE NOTED DATE/TIME
This is the date that this occurrence was noted. The time of day can be entered, but is not required.

3 TREATMENT INSTITUTED FREE TEXT
This is the type of treatment instituted as a result of this non-O.R. procedure occurrence.

4 OCCURRENCE COMMENTS WORD-PROCESSING
This is information that may be helpful in documentation of the non-O.R. procedure occurrence.

5 OCCURRENCE CATEGORY POINTER
This is the name of the category for which this occurrence will be grouped for Surgery Central Office reporting needs.

127 SEQUENTIAL COMPRESSION DEVICE SET
This determines whether a sequential compression device was used.

128 LASER TYPE FREE TEXT
This determines whether a laser was used during this procedure. If applicable, enter the type of laser used during this surgical procedure.

200 OPERATIONS THIS ADMISSION NUMERIC
This is the total number of surgical procedures, prior to the index or principal operation, which required the patient to be taken to the operating room for any type of surgical intervention during this hospital admission. Include all procedures whether or not they are part of the inclusion/exclusion criteria.

201 REDO PROCEDURE SET
This determines whether the principal operative procedure was a reoperation in the same anatomic location for the same purpose as the first operation regardless of the length of time from the original surgical date.

202 CURRENT SMOKER SET
For non-cardiac assessment, did the patient smoke cigarettes in the year prior to admission for surgery?

For cardiac assessment, did the patient smoke tobacco in any form in the 2 weeks prior to surgery?

202.1 PACK/YEARS NUMERIC
If the patient has ever been a smoker, enter the total number of pack/years of smoking for this patient. The number of pack/years is determined by multiplying the number of packs of cigarettes smoked per day by the number of years the patient has smoked. If the patient has never been a smoker, enter "0". If the smoking history for this patient cannot be determined, enter "NS". The possible range for number of pack/years is 0 to 200.

203 HISTORY OF COPD SET
This determines whether the patient has chronic obstructive pulmonary disease (COPD) resulting in functional disability, and/or hospitalization, and/or requiring chronic bronchodilator therapy, and/or an FEV1 of less than 75% of predicted.

For non-cardiac assessment, do not include patients with acute asthma, an acute and chronic inflammatory disease of the airways resulting in bronchospasm.

204 VENTILATOR DEPENDENT SET